EDN TB Follow-Up Worksheet

A. Demographic Last reviewed: 6/21/2013

A1. Name (Last, First, Middle): ,	**A2. Alien #:**	**A3. Visa type:**	**A4. Initial U.S. entry date:**
A5. Age: / A6. Gender:	A7. DOB: ___/___/_____	A8. TB Class:	

A9.Country of examination: | A10.Country of birth:

A11a. Address:
A11b. Phone:
A11c. Other:

A12. a. Sponsor agency name:
b. Phone(s):
c. Address:

B. Jurisdictional Information

B1. Arrival jurisdiction: | B2. Current jurisdiction:

C. U.S. Evaluation

C1. Date of Initial U.S. medical evaluation: ___/___/_____

Mantoux Tuberculin Skin Test (TST)

C2a. Was a TST administered? ☐ Yes ☐ No ☐ Unknown

*If **YES,*** C2b. TST placement date: ___/___/_____
☐ Placement date unknown

C2c. TST mm: _____ ☐ Unknown

C2d. TST interpretation: ☐ Positive ☐ Negative ☐ Unknown

C2e. History of Previous Positive TST ☐

Interferon-Gamma Release Assay (IGRA)

C3a. Was IGRA administered? ☐ Yes ☐ No ☐ Unknown

*If **YES**,* C3b. Date collected: ___/___/_____ ☐ Date unknown

C3c. IGRA brand: ☐ QuantiFERON® ☐ T-SPOT ☐ Other (specify):

C3d. Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Invalid ☐ Unknown

C3e. History of previous positive IGRA ☐

U.S Review of Pre-Immigration CXR

C4. Pre-immigration CXR available?
☐ Yes ☐ No ☐ Not Verifiable

C5. U.S. interpretation of pre-immigration CXR:
☐ Normal
☐ Abnormal (must select one below):
- ☐ Not consistent with active TB
- ☐ Non-cavitary, consistent with TB
- ☐ Cavitary, consistent with TB

☐ Poor Quality
☐ Unknown

C6. Other pre-immigration CXR abnormalities:
☐ Volume loss ☐ Infiltrate ☐ Granuloma(ta)
☐ Adenopathy ☐ Other (specify)

U.S. Domestic CXR

C7. U.S. domestic CXR done?
☐ Yes ☐ No ☐ Unknown

*If **YES**,* C8. Date of U.S. CXR: ___/___/_____

C9. Interpretation of U.S. CXR:
☐ Normal
☐ Abnormal (must select one below):
- ☐ Not consistent with active TB
- ☐ Non-cavitary, consistent with TB
- ☐ Cavitary, consistent with TB

☐ Unknown

C10. U.S. domestic CXR abnormalities:
☐ Volume loss ☐ Infiltrate ☐ Granuloma(ta)
☐ Adenopathy ☐ Other (specify)

Comparison

C11. U.S. domestic CXR comparison to pre-immigration CXR:
☐ Stable
☐ Worsening
☐ Improving
☐ Unknown

U.S. Review of Pre-Immigration Treatment

C12a. Completed treatment pre-immigration? ☐ Yes ☐ No

*If **YES**,* ☐ Treated for TB disease ☐ Treated for LTBI

C12b. Treatment start date: ___/___/____ ☐ Start date unknown

C12c. Treatment end date: ___/___/____ ☐ End date unknown

C12d. Treatment reported by:
- ☐ Treatment documented on DS forms
- ☐ Patient reported treatment completion **at** or **before** panel physician examination
- ☐ Both-documented on DS forms & patient reported
- ☐ Unknown

C12e. Standard TB treatment regimen was administered?
☐ Yes ☐ No ☐ Unable to verify

C13. Arrived on treatment?
☐ Yes ☐ No ☐ Unknown

If YES, ☐ TB disease ☐ LTBI

C13a. Start date: ___/___/____ ☐ Start date unknown

C14: Pre-Immigration treatment concerns?
☐ Yes ☐ No

*If **YES**,*
- ☐ Treatment duration too short
- ☐ Incorrect treatment regimen
- ☐ Other, please specify:

Alien #	EDN TB Follow-Up Worksheet (Cont)	Last reviewed: 6/21/2013

C15. U.S. Microscopy/Bacteriology* Sputa collected in U.S.? ☐ Yes ☐ No **Covers all results regardless of sputa collection method.*

#	Date Collected	AFB Smear	Sputum Culture	Drug Susceptibility Testing
1	___/___/_____	☐ Positive ☐ Negative ☐ Not Done ☐ Unknown	☐ NTM ☐ MTB Complex ☐ Contaminated ☐ Negative ☐ Not Done ☐ Unknown	☐ MDR-TB ☐ Mono-RIF ☐ Mono-INH ☐ Other DR ☐ No DR ☐ Not Done
2	___/___/_____	☐ Positive ☐ Negative ☐ Not Done ☐ Unknown	☐ NTM ☐ MTB Complex ☐ Contaminated ☐ Negative ☐ Not Done ☐ Unknown	☐ MDR-TB ☐ Mono-RIF ☐ Mono-INH ☐ Other DR ☐ No DR ☐ Not Done
3	___/___/_____	☐ Positive ☐ Negative ☐ Not Done ☐ Unknown	☐ NTM ☐ MTB Complex ☐ Contaminated ☐ Negative ☐ Not Done ☐ Unknown	☐ MDR-TB ☐ Mono-RIF ☐ Mono-INH ☐ Other DR ☐ No DR ☐ Not Done

D. Evaluation Disposition

D1. Evaluation disposition date: ___/____/_____

D2. Evaluation disposition:

☐ Completed evaluation ☐ Initiated Evaluation / Not completed ☐ Did not initate evaluation

If evaluation was completed, was treatment recommended?

☐ Yes ☐ No

☐ LTBI

☐ Active TB

If evaluation was NOT completed, why not?

☐ Not Located ☐ Moved within U.S., transferred to:

☐ Lost to Follow-Up ☐ Moved outside U.S.

☐ Refused Evaluation ☐ Died

☐ Unknown ☐ Other, specify

D3. Diagnosis

☐ Class 0 - No TB exposure, not infected ☐ Class 1 - TB exposure, no evidence of infection

☐ Class 2 - TB infection, no disease ☐ Class 3 - TB, TB disease

☐ Class 4 - TB, inactive disease ☐ Pulmonary ☐ Extra-pulmonary ☐ Both sites

D *If diagnosed with TB disease,* ☐ RVCT Reported D5. RVCT #: ☐ RVCT # unknown

E. U.S. Treatment

E1. U.S. treatment initiated: ☐ Yes ☐ No ☐ Unknown

*If **NO**, specify the reason:*

☐ Patient declined against medical advice ☐ Lost to follow-up ☐ Moved within U.S, tranferred to:

☐ Died ☐ Moved outside the U.S. ☐ Other (specify)

☐ Unknown

*If **YES**:* ☐ TB disease ☐ LTBI

E2. Treatment start date: ___/____/_____

E3. U.S. treatment completed: ☐ Yes ☐ No ☐ Unknown

*If **NO**, specify the reason:*

☐ Patient stopped against medical advice ☐ Lost to follow-up ☐ Adverse effect

☐ Provider decision ☐ Moved outside the U.S. ☐ Moved within U.S, tranferred to:

☐ Died ☐ Unknown ☐ Other (specify)

If treatment was completed, E4. Treatment completion date: ___/____/_____

If treatment was iniated but NOT completed, E5. Treatment end date: ___/____/_____

F. Comments

G. Screen Site Information

Provider's Name:

Clinic Name:

Telephone Number: